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HEALTH CARE DELIVERY: The HMO Alternative

A health maintenance organization (HMO) is, among many other things, an instrument of change.

The HMO has been put forward as one answer to the needs of the people of the United States for improved health care. This answer has been proposed at a time when there is almost universal agreement that some form of change—change for the better—is necessary. The health maintenance organization format has been recommended by the present Administration as a free-enterprise approach to solving the problem. HMO legislation has drawn wide, bipartisan support. It is apparent that the HMO will play an increasingly important role in health care.

The characteristics which distinguish the HMO approach from conventional health care methods are a combination of prepayment for services and responsibility for providing a total health care delivery system. Prepaid medical care is already familiar on the American scene. It is basic to the indemnity insurance approach to health care. However, the typical insurance carrier plays a pass-through role financially. Prepaid funds of the assured are converted into fees for specific services by physicians and other providers. By contrast, the HMO brings together—either on a staff or contract basis—the doctors, the laboratories, the clinics, the hospitals, the educational efforts, and any other ingredients necessary to provide full, comprehensive health care to members.

The HMO, like other health insurance plans, is based on voluntary membership. Therefore, in offering its services, the HMO introduces an alternative—competition. Potential sponsors or subscribers to health care plans will increasingly be offered a choice between the fee-for-service approach which is predominant today and the total care concept of the HMO.

These choices will be faced by a number of different audiences:

Employers will be asked to offer HMO group coverage as an alternative to present plans.

Consumers will face the ultimate choice between present health care delivery systems and a total HMO package.

Government agencies and officials are expected to move en masse to provide HMO services as an alternative means of care for medically indigent persons and for persons covered under Medicare.

Labor organizations will be negotiating extensively with employers over the alternatives offered by the HMO

approach. For the employer, the underwriting of health care plans has become a major cost of doing business. For the labor organization, increased health care benefits have become a bargaining point. Many labor leaders feel they have given up potential increases in wages to secure improved health care. They feel also that a reduction in health care costs through HMO programs can put more money into paychecks of their members.

Thus, the HMO emerges as a vehicle of change in an environment predisposed to change. A further understanding of the HMO, then, calls for a review of the health care elements subject to change—and of the problems the HMO purports to solve. These are generally divided into three categories: availability, cost and quality.

AVAILABILITY

One of the prime requisites for any medical care system, obviously, is that people must be able to avail themselves of the services and facilities. One measure of availability for health care is the ratio of doctors to the general population. On a national average, there are 150 doctors for each 100,000 population and this ratio is considered adequate by medical professionals. However, distribution of these services is anything but uniform. Some areas have far more than average medical services. Others suffer a dearth: the Kenwood area of Chicago functions with a ratio of five physicians for each 100,000 persons.

The same problem plagues rural America. A specific and dramatic example of medical accessibility problems can be seen in Crawford County, Indiana. In this area, spread across 40 miles of mid-America, there is one physician for each 8,033 persons—a ratio of about 12 per 100,000. Compounding this problem is the prospect of distances of 10 to 20 miles between doctors and persons who may be ill.

As dramatic as they are, these numbers tell only part of the story. Adequate medical care today has a far different look than it did 30 or 40 years ago. Procedures such as kidney transplants or open-heart surgery are becoming commonplace life extension techniques. These procedures require whole teams of specialists attending to individual patients. Also considered as basic requirements today are exotic medication, scientific equipment, and highly trained technicians to apply them. Lack of these facilities and capabilities in central city and rural areas broadens the accessibility gap.

COST

Expenditures for health care have been battered from two directions: vastly increased use of health services and runaway inflation affecting professional fees and other charges. Aggregate expenses for health care have grown at an average rate of 7.3 percent annually for 20 years. This far outstrips growth of either personal income or the economy as a whole.

There is a close relationship between rate of expense and the best interests of consumers and providers of health care. Conventional health insurance programs within the United States are oriented toward hospitalization benefits. Under most plans now in force, both benefits and conveniences are greater for patient and doctor if care is rendered in a hospital. Since hospitalization is the most expensive element of medical care, inflationary pressures appear to be built into most current health care programs.

QUALITY

Quality in health care has two separate aspects: continuity of service to patients and scientific caliber of treatment.

One of the classic questions about the quality of medical care is whether doctors treat diseases or patients. The human side of medicine is considered vital. Yet, in the clinical approach to medicine which has been practiced among the poor, a continuity of relationship has frequently and lamentably been missing.

The other side of health care quality lies in professional accountability. Doctors, nurses, and other medical personnel should be subjected to review of work performed. They should be judged by their peers and held accountable for breaches in quality. Suitable quality control mechanisms exist intermittently. Only a few states have established adequate review and responsibility programs.

ALTERNATIVE SOLUTIONS

The problems listed above are widely recognized. The desire for solution and improvement is also widespread. Alternative solutions, which are not mutually exclusive, include:

1. National health insurance
2. Professional manpower development
3. A restructuring of the health care industry under federal control—socialized medicine
4. Locally managed, independent health maintenance organizations.

National Health Insurance

One approach to the need for improved health care lies in expansion of insurance coverage, which is today the largest single source of financing for private health care. Various proposals have been advanced. In general, these call for the setting of minimum health insurance standards for all citizens. Under most plans, insurance would still be underwritten by private carriers. Costs would be borne by a combination of sources, including employers, individuals, tax credits, and government subsidies for the poor and near-poor.

Such plans would have the benefit of providing additional financing for medical care. However, as with Medicare, the potential drawback lies in the fact that additional funding is provided without changing or expanding sources of supply. Thus, opponents of such plans maintain that, if supplies of medical services are not increased commensurately, they would have an inflationary effect without providing long-term solutions.

Manpower Training

One of the acute areas of the health care problem is seen as a shortage of qualified doctors and nurses. Accordingly, federal programs were initiated in 1971 to increase support to medical and nursing schools. Facilities and programs for training increasing numbers of doctors and nurses are expected for the near future. Associated programs will be aimed at encouraging new doctors to practice in rural and central-city areas. Increasing the supply of doctors and nurses, it is felt, will improve accessibility to medical care. The increase in the number of physicians is also expected, ultimately, to have a supply-and-demand effect on costs of medical services.

Federal Health Care

This approach would nationalize the \$75 billion health care industry. The government would own health care facilities. Doctors would derive their income primarily from federal programs. Individuals and companies would be taxed to support the new structure.

In fact, this is a plan for socialized medicine. The government would assume management, as well as funding responsibilities.

Until the recent trend toward HMO programs, direct federal control in some form was considered inevitable by many. Opponents of such plans pointed to difficulties with socialized medicine in England. There has been widespread feeling that the government would be both

unable to operate a medical delivery system and also to respond to both demands and requirements for change.

Support for actual government operation of medical care systems appears to have diminished among members of both parties in Congress.

Health Maintenance Organizations

The health maintenance organization approaches medical care requirements through restructuring what is generally called the health care delivery system. A single organization, functioning on a local basis with close community coordination, serves both to finance and provide health care services. The HMO makes arrangements for necessary facilities for health care, either by building its own clinics and hospitals or contracting for services from existing organizations. Similarly, depending on state laws, services of doctors are procured either on a staff or contract basis.

The HMO attacks all three categories of the health care structure—availability, cost, and quality. Availabil-

ity is dealt with through the employment or contracting of services to meet the demands of specific member groups. A close correlation can be established between members' needs and professional service levels.

The cost problem is attacked through incentives to increase the use of outpatient treatment and reduce hospital confinement. This happens because the HMO is oriented toward and responsible for total health care of its members. The basic emphasis on hospitalization in normal insurance programs is diminished. It is to the advantage of both patient and doctor to use integrated outpatient and hospitalization facilities to best advantage. In some cases, incentives are actually established to minimize excessive hospitalization of patients.

Quality of care is dealt with within the HMO structure through the establishment of a peer group with accountability mechanisms. Diagnoses and treatments of doctors are reviewed. Further, within the group-type mechanism set up by an HMO, doctors can take time for research or advanced study on a regular basis.

Professional review can be applied to total patient

HMO Background

For all of the attention it is currently receiving, the HMO is not new — either in concept or practice. Its origins were pragmatic rather than idealistic. This background is typified by the experience of the largest, and certainly the first significant, health maintenance organization in the country — the Kaiser-Permanente Medical Care Program.*

This group grew out of an ingenious solution to a problem. A young physician, graduating from medical school in Los Angeles in 1933 with few practice opportunities open, offered his services to workers building an aqueduct to carry water from Hoover Dam to Los Angeles. The young physician financed a 10-bed portable hospital to follow the project across the desert. After a number of disappointments, a program was developed for prepayment of care for all of the workers on the project. Half the cost was underwritten by a work-

men's compensation insurance carrier, the rest through payroll deductions.

The plan worked so well in the building of the aqueduct that the doctor was invited to set up his program for workers on the Grand Coulee Dam project in remote eastern Washington. In this case, the service was expanded to include families of the workers. The program grew still further when the Kaiser organization went into shipbuilding and steelmaking during World War II. At the end of the war, a number of workers requested continuation of the program. At the time, there were 40,000 members. Today there are more than 2.1 million.

These members are provided with complete health care from a single source. Patients contract with the Kaiser Foundation Health Plan. This entity, in turn, deals with closely affiliated organizations which provide outpatient care and hospitalization. The parent organization enrolls members

care. This represents an expansion from conventional practices where doctors are subject to review for treatments or procedures performed in hospitals but are generally not held accountable for practices within their own offices or within outpatient clinics.

NEW DIRECTIONS

While a number of groups have been individually successful and have proved the viability of the HMO concept, they have not formed a major trend in health care. At the beginning of 1972 an estimated 8 million persons were covered by HMOs and other prepaid health care plans, substantially less than 5 percent of the population of the United States.

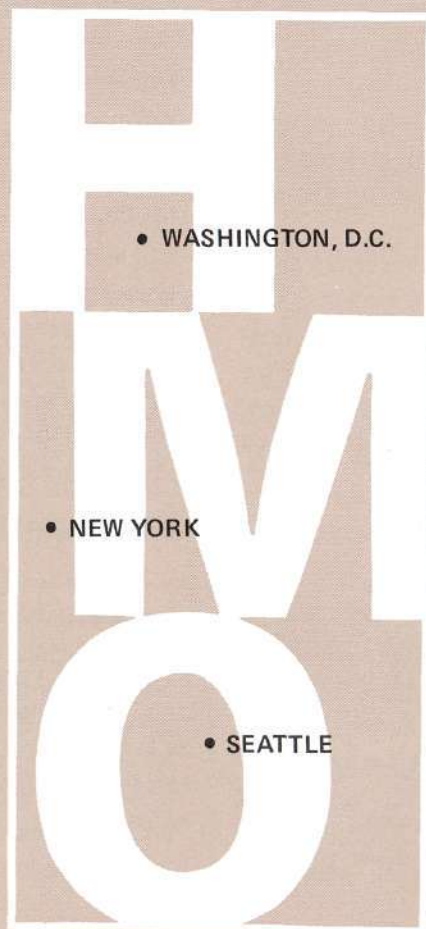
The present Administration has given added impetus to the HMO concept. One of the goals of its National Health Strategy is to make the HMO option available for enrollment by 90 percent of the population by 1980. Three key objectives adopted in support of this goal include:

- To convert federal, state, local, and private purchases of health care into the HMO option
- To provide a comprehensive range of technical assistance services and financial support to health maintenance organizations for planning, development, and initial operation
- To educate consumers and providers of health care in HMO concepts and operations—and on their potential roles in HMO development.

Thus, it becomes highly significant that the HMO concept has been proven independently and privately with services to a small portion of the population. The principles proven by these few existing organizations promise now to become solid building blocks for a health care delivery technique which the present Administration has committed to preeminence. In addition, at this time, legislative calendars are replete with congressional, as well as Administration, bills for the furtherance of the HMO concept.

on a flat rate, or capitation, basis. In turn, the central health plan contracts with medical groups for physicians' services and with hospitals for inpatient facilities and care. These contracts, too, are on a capitation basis. They call for a fixed fee on an annual basis for each member enrolled in the plan.

Cost of hospitalization is the key to economies and profits. Since hospitalization is the main expense, hospital confinement is used only as really necessary for patients. Tests and medical "workups" are done chiefly on an outpatient basis. Average days of hospital confinement for Kaiser Health Plan members run between one-third and 50 percent less than for the population at large in the area served. Benefits from the more advantageous mix of outpatient and inpatient care are passed along to members and doctors. Members receive prepaid care for lower fees. Doctors benefit through bonuses derived from an advantageous mixture of inpatient and outpatient care.



Other HMO Pioneers

A number of successful health maintenance organizations were formed across the country during the era preceding and following World War II. These organizations have proved that the HMO concept can work — that it can be a viable health care delivery system. Frequently cited examples of successful HMO operations include:

- The Group Health Association,* Washington, D.C., a prepaid group plan contracting with independent doctors and hospitals. The group has some 80,000 members.
- The Health Insurance Plan,* formed in New York in 1947. Its enrollment now numbers some 750,000.
- The Group Health Care Cooperative of Puget Sound, Seattle, Washington, also formed shortly after World War II. Its enrollment is now in the neighborhood of 120,000.

* Touche Ross client

HMO CHARACTERISTICS

To appreciate the potential and the impact of the HMO, it would be well, at this point, to take a closer look at the structure and characteristics of a typical HMO.

A health maintenance organization is a prepaid group practice providing a medical care delivery system which accepts responsibility for the organization, financing, and delivery of health care services for a defined population. These services are delivered on a prepaid basis to members who enroll voluntarily.

Six characteristics of an HMO are worth noting:

Responsibility for Organizing and Delivering Health Services

An HMO is frequently described as a complete health care delivery system. The accent is on the delivery system. This separates an HMO from a health insurance plan. The insurance underwriter is primarily a pass-through for money, with no medical service management, no responsibility for selection of physicians and facilities. An HMO pulls together a total health care system.

Typically, this is done on a capitation basis. The health care organization subcontracts with groups of physicians for medical services and with hospitals for facilities and inpatient care—each on a flat fee per member per year. Some HMO arrangements call for fee-for-services arrangements with hospitals while doctors operate on a capitation basis. But the full capitation plan promises to become most widely practiced.

Under full capitation agreements, an important characteristic of the health maintenance organization is that the plan itself is not at risk. Provider groups and hospitals assume risks for caring for all of the health care needs of the entire enrolled population at stipulated fees per capita. These fees are not dependent upon the actual amount of services utilized.

Voluntary Enrollment

It is basic to the HMO concept that this is not a universal delivery system for health care. An HMO is seen as an alternative. Typically, a large corporation would offer employees a choice between membership in an HMO or a health insurance plan. Many corporate managers are already encountering this optional approach. To illustrate, the United Auto Workers has negotiated the HMO option into contracts with the employers—even though an HMO may not exist in the immediate

plant areas. The same option is seen applying to Medicaid patients.

Consumer Orientation

A characteristic which accompanies the voluntary nature of HMO enrollment is community responsiveness. In each case, HMO members play advisory and policy-making roles within the group. Since these community members are also members of the plan, they are in an excellent position to advise on what services should be rendered and to evaluate their reception. In addition, member participation on advisory and policy groups serves a quality-control function in that members are in a direct position to compare actual services with those planned and specified.

Prepayment

Prepayment of fees for total health care is basic to an HMO plan. On the surface, this feature of an HMO plan appears similar to payments to indemnity insurance plans.

The basic use of fees, however, is vastly different. In an indemnity program, fees go into a pool for application against insured risks. Under an HMO, income from fees is used for operations. Fees become the basis for planning and budgeting—particularly for the negotiation of capitation rates with providers of health care.

Group Practice

Since one of the basic objectives of an HMO is to provide comprehensive health care, it follows that medical services must be rendered by a balanced group of physicians—or a group practice. HMO proponents hold that the establishment of a group enhances the comprehensiveness of care available through inclusion of a range of medical specialties. In addition, the existence of a group of medical peers makes it possible to establish and enforce quality standards.

Comprehensive Benefits

Provision of both medical care and hospitalization requirements of members is a basic tenet of an HMO. A typical HMO will provide for all of a member's normal office visits with his physician, diagnostics on an out-patient basis, laboratory services, X-rays, and so on. By contrast, many health insurance plans place emphasis on hospitalization and offer only limited coverage for routine medical service. This characteristic has led to the practice of extensive—possibly excessive—use

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of hospital facilities for nonacute illnesses. Conversely, the ability to provide a broad range of services needed by members is one of the features which keeps hospital utilization rates down for an HMO. The accompanying table shows comparative figures for typical hospital utilization rates by members of health insurance groups and HMO plans.

Hospital Utilization for Several Group Prepayment Plans (HMOs) Compared with a Prepayment Insurance Plan

| Plan | Admissions per 1000 Population | Average Length of Stay | Patient Days per 1000 Population |
|------------------------------|--------------------------------------|------------------------------|--|
| A | 78 | 7.4 | 577 |
| B | 94 | 5.8 | 542 |
| C | 89 | 7.8 | 696 |
| D | 91 | 5.6 | 579 |
| E | 113 | 8.3 | 947 |
| F | 8 | 6.5 | 534 |
| Prepayment Insurance Plan | 149 | 8.1 | 1,209 |

Even more important, comprehensive coverage is basic conceptually to an HMO. The ability to provide examination and diagnostic services routinely on an out-patient basis is health maintenance. Proponents feel this provides an opportunity to discover and deal with illnesses before they become critical enough to require hospitalization.

DISADVANTAGES

Descriptions of the characteristics and functions of an HMO up to this point have stressed their good points, or advantages. In considering the full implication of an HMO as a health care delivery system, disadvantages are also worth noting. At least two of these can be identified:

Continuity of medical care between doctor and patient is more subject to interruption under an HMO than in private-practice situations. A physician with his own practice tends to be part of his community for a long term. He tends to cultivate and maintain patient relationships from one generation of a family to the next. This has been part of the long-standing tradition of American medicine.

Most HMO organizations will attempt to assign doctors to specific patients. However, in an HMO, these relationships are more subject to disruption. Doctors may be transferred as new offices are opened. Patients may be reassigned as new doctors are employed to relieve busy schedules for established physicians. As HMOs proliferate, they will tend to create the equivalent of a job market for doctors, who will be able to further their careers through movement in the same manner as business executives. Thus, to the extent that continuity of relationship represents quality of medical care, this facet of an HMO may be less stable than in a private-practice situation.

Another potential disadvantage centers around the frequently expressed concern over incentives to minimize hospitalization. Many persons have expressed concern that, because doctors and hospitals are encouraged to minimize admissions, some seriously ill persons may be neglected. Also, concern has been expressed that persons who are hospitalized may be discharged before they have recuperated sufficiently. This article will certainly not comment on these possibilities. It should be noted, however, that these fears have been expressed and should be considered as a potential disadvantage of an HMO.

IMPLICATIONS FOR BUSINESSMEN

Businesses, like every other segment of American society, will be impacted by HMO developments. As with

any other social or economic trend, the businessman has two choices: he can react or he can lead.

Reaction would involve minimal, after-the-fact support. After a community or government group had initiated and formed an HMO, the businessman could make it available as an alternative for his employees. He could then provide the minimal support of payroll deductions, information dissemination, handling of inquiries or complaints, and so on. Many businessmen will undoubtedly follow such a course.

For a businessman with imagination, however, the HMO phenomenon holds some potential for growth and development. For one thing, the businessman intent on securing the best in benefit packages for his employees can instigate or lead the development of an HMO in his community or in his company. The door is certainly open for such activity. The HMO concept itself arose from the solution to a business problem in the area of employee

services.

In addition, a number of companies are known to be investigating the potential of the HMO as a profit-making venture. The opportunities, limitations, or restrictions on such ventures are not at all clear yet. But just as the health care market is attracting venturesome and imaginative businessmen in other sectors, the HMO will surely come in for its share of investigation.

At the very least, many businessmen are taking encouragement from the HMO trend. Recognizing that a health care problem—many identify it as a crisis—does exist, the HMO is a free-enterprise solution. The HMO is seen as an approach which is far and away preferable to direct government sponsorship, management, or active participation in the health care process. At the very least, the emergence of this free-enterprise solution to a pressing problem of society is seen as encouraging and interesting by many businessmen. ■